Louisiana's LaMOMS Program

LaMOMs is a no cost health insurance for pregnant women provided by Louisiana's Medicaid program.

How to Apply

① **Online** – www.Medicaid.DHH.Louisiana.gov.

② **Mail –** Mail the application and documents of proof to:

LaMOMS
P.O. Box 91278
Baton Rouge, LA
70821-9278

③ **Fax –** Fax the application and documents of proof to 1-877-523-2987 (toll-free)

④ **Drop Off –** Drop off the application and documents of proof at your local Medicaid Office. Call 1-888-342-6207 for the closest office or visit our web site at www.LaMOMS.DHH.Louisiana.gov.

We Look at Your Family's Income

We count gross income, not take-home (net) pay. Income limits are based on family size. Your family includes you (the pregnant woman), your husband (if legally married), children under age 18, and the unborn child.

If your income is more than what is shown in the chart, you may still qualify, because we allow deductions like:

- ✓ Child support payments to someone **outside** of your home
- ✓ $90 for each employed person
- ✓ Childcare payments: Up to $200 for children **under** age 2, $175 **over** age 2
- ✓ Up to $50 for child support **received**

Number in Family	Income Amounts through March 31, 2011	
	Weekly Income	Monthly Income
2	$607	$2,429
3	$763	$3,052
4	$919	$3,675
5	$1,075	$4,299
6	$1,231	$4,922
7	$1,386	$5,545
8	$1,542	$6,169
For each extra person, add $600 to the monthly amount.		

After You Apply

We will send you a letter to let you know if you qualify. If you do, you will get a Medicaid card about 2 weeks following the approval letter. If you already have a Medicaid card, we will reactivate it and you can start using it as soon as you get the approval letter.

Covered Services

LaMOMs covers all pregnancy related services, delivery, and care throughout your pregnancy and up to 60 days after your pregnancy ends.

Coverage includes:

- ★ Doctor visits
- ★ Lab work and tests
- ★ Hospital care
- ★ Prescription medicines
- ★ Some dental services for gum disease.

Other Health Insurance

You can have both private health insurance and LaMOMS. To get all the benefits of LaMOMS, the doctor you choose must accept both LaMOMS or Medicaid **and** your other insurance. Your other insurance will pay first; then we will pay.

If you have or can get insurance through a job, Medicaid may help pay the premiums. Call 1-866-362-5253 or go online at www.LaHIPP.DHH.Louisiana.gov for more information.

You Choose Your Doctor

You may get care from any doctor who accepts Medicaid. For a list of doctors in your area, call 1-877-455-9955. This is a free call.

Help with Past Medical Bills

We can see if you qualify for LaMOMS to pay for medical services you received during your pregnancy even if you have already paid the bill.

Additional Help

"Partners for Healthy Babies" is a project of the Louisiana Office of Public Health. They can give you information about your pregnancy and tell you about other available programs. Call "**Partners for Healthy Babies"** at 1-800-251-BABY (251-2229). This is a free call.

(TEAR OFF THE APPLICATION BEFORE MAILING. KEEP THIS PAGE.)

Questions

If you have questions or need help filling out the application or getting any of the things we ask for, call **1-888-342-6207**. If you are deaf or hard of hearing **and** use a TTY text telephone, call **1-800-220-5404**. These calls are free.

LaMOMS is an Equal Opportunity Program

Medicaid/LaMOMS cannot treat you differently because of your race, color, sex, age, disability, religion, nationality or political beliefs. If you think we have, you may:

- Call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019; OR
- Write to:
  LA Dept. of Health & Hospitals
  P. O. Box 4818
  Baton Rouge, LA 70821-4818; OR
- Call or write to your local Medicaid office

Your Rights

If you think the decision we make is unfair, not correct or made too late, you may ask for a fair hearing.

- Call the Medicaid office at 1-888-342-6207; OR
- Write to:
  LA DHH Bureau of Appeals
  P. O. Box 4183
  Baton Rouge, LA 70821-4183; OR
- Call or write to your local Medicaid office

¿Necesita traductor de español? Llame al 1-877-252-2447.

Quí vị có cần thông dịch viên người Việt không? Nếu cần xin gọi số 1-877-252-2447.

This public document was published at a total cost of $15,525.14. Fifty thousand (50,000) copies of this public document were published in this first printing at a cost of $15,525.14. The total cost of all printings of this document, including reprints, is $15,525.14. This document was published by Office of State Printing, 950 Brickyard Lane, Baton Rouge, LA 70804 to advise applicants, recipients and other individuals of LaMOMs coverage available through the Medicaid Program under authority of 42 CFR 435.905 (a)(1) and Act 128 of the 1998 1st Extraordinary Session of the Louisiana Legislature. This material was printed in accordance with the standards for printing by state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with provisions of Title 43 of the Louisiana Revised Statutes.

BHSF Form 1-PW Cover
Rev. 04-10
Prior Issue Obsolete

LOUISIANA Department of HEALTH and HOSPITALS

Application for

LaMOMS

No-Cost Health Insurance for Pregnant Women

Helping Pregnant Women Have Healthier Babies

Apply Online at
www.LaMOMS.DHH.Louisiana.gov

1-888-342-6207

BHSF Form 1-PW
Rev. 04/10
Prior Issue Obsolete

LaMOMS
No-Cost Health Insurance for Pregnant Women

Application

Use this application to apply for LaMOMS or Medicaid for pregnant women. You may also apply online at www.Medicaid.DHH.Louisiana.gov.

To apply:

1. **Fill out this application with a black ink pen.**
2. **Get the documents of proof we need.**
3. **Send this application and documents of proof to us right away.**
   We will give you extra time to send in the proofs if you need it.

LaMOMS
P.O. Box 91278
Baton Rouge, LA 70821-9278
FAX: 1-877-523-2987

What language do you speak best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (tell us)*_____
What language do you write best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (tell us)* _____

Si usted quiere una solicitud en español o quiere hablar con alguien que habla español, llame al 1-877-252-2447.
Nếu quí vị cần đơn tiếng Việt hoặc tham khảo với nhân viên người Việt, Xin gọi số điện thoại miễn phí 1-877-252-2447.

1. Where did you get this application?

❑ LaMOMS/Medicaid Office ❑ Hospital ❑ Pharmacy ❑ Doctor's Office ❑ Friend/Relative
❑ Internet ❑ School Clinic ❑ Food Stamp Office ❑ Health Unit ❑ Business (Store, Work)
❑ Festival/Health Fair ❑ Somewhere else: _____

2. Information About You (the pregnant woman who is applying)

Name _____
First *Middle Initial* *Last*
Maiden Name _____

Social Security Number _____ Date of Birth _____
Month *Day* *Year*

Race/Ethnic Background (Optional - you may mark one or more): ❑ White ❑ Black ❑ Hispanic or Latino
❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander

Place of Birth: State (if born in the U.S.)_____ Country (if born outside the U.S.)_____

Mother's Maiden Name _____

Are you a U.S. citizen? ❑ Yes – Go to Question 3 ❑ No – Fill Out Below

Are you a lawful permanent resident? ❑ Yes ❑ No Date You Came to U.S. _____

Permanent Resident Card Number (green card): A _____

3. How to Reach You

Mailing Address _____ Apartment/Lot # _____

City _____ State _____ Zip _____

Home address (if different) _____ Apartment/Lot # _____

City _____ State _____ Zip _____

Parish _____ Home Phone (_____) _____

Cell Phone (_____) _____ Daytime Phone (_____) _____

E-mail Address _____

What is the best day and/or time to call you during our office hours, Monday – Friday, 8 a.m. – 4:30 p.m.?

_____

Questions - Call 1-888-342-6207 (free call)
(TTY text telephone for deaf and hard of hearing: 1-800-220-5404)

4. What is your best guess of your due date? _____
Are you expecting more than one baby? ❑ Yes ❑ No

5. Give us information about your legal husband who lives with you. If you are under age 18, list your parents who live with you. ❑ None – Go to Question 6 ***Do not list step-parents.***

Person #1

Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Date of Birth_____ Social Security Number_____
Month *Day* *Year*

Race/Ethnic Background (Optional - you may mark one or more): ❑ White ❑ Black ❑ Hispanic or Latino
❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander

Relationship to You: ❑ Husband ❑ Parent

Person #2

Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Date of Birth_____ Social Security Number_____
Month *Day* *Year*

Race/Ethnic Background (Optional - you may mark one or more): ❑ White ❑ Black ❑ Hispanic or Latino
❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander

Relationship to You: ❑ Husband ❑ Parent

6. List ALL children under age 19 who live with you. ❑ None – Go to Question 7

If you are under age 18, list your brothers and sisters under age 19. If there are more than 4 children, use a separate sheet of paper.

A. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Date of Birth_____ Social Security Number_____
Month *Day* *Year*

Race/Ethnic Background (Optional - you may mark one or more): ❑ White ❑ Black ❑ Hispanic or Latino
❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander

Relationship to You: ❑ Child ❑ Stepchild ❑ Brother/Sister ❑ Other: _____

B. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Date of Birth_____ Social Security Number_____
Month *Day* *Year*

Race/Ethnic Background (Optional - you may mark one or more): ❑ White ❑ Black ❑ Hispanic or Latino
❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander

Relationship to You: ❑ Child ❑ Stepchild ❑ Brother/Sister ❑ Other: _____

C. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Date of Birth_____ Social Security Number_____
Month *Day* *Year*

Race/Ethnic Background (Optional - you may mark one or more): ❑ White ❑ Black ❑ Hispanic or Latino
❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander

Relationship to You: ❑ Child ❑ Stepchild ❑ Brother/Sister ❑ Other: _____

D. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Date of Birth_____ Social Security Number_____
Month *Day* *Year*

Race/Ethnic Background (Optional - you may mark one or more): ❑ White ❑ Black ❑ Hispanic or Latino
❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander

Relationship to You: ❑ Child ❑ Stepchild ❑ Brother/Sister ❑ Other: _____

7. Is anyone working? ❑ Yes – Fill Out Below ❑ No – Go to Question 8

Tell us about wages or cash received from working, self-employment, and tips for you and your husband. If you are under age 19, tell us your parents' information (not step-parents).

Who works?	Employer's Name _____ Employer's Phone Number _____ ❑ Self-employed	How much is received (show gross, not take home pay)? $ _____ How often? ❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly	Is insurance offered? ❑ Yes ❑ No
Who works?	Employer's Name _____ Employer's Phone Number _____ ❑ Self-employed	How much is received (show gross, not take home pay)? $ _____ How often? ❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly	Is insurance offered? ❑ Yes ❑ No

8. Are you on maternity leave from your job? ❑ Yes ❑ No

9. Does anyone get money that is not from a job like the kinds listed below?

- Social Security
- SSI
- Unemployment
- Worker's Comp
- Money from Friends/Relatives
- Child Support (*list the child as the person who gets it*)
- Alimony
- Something else (*list below*)

❑ Yes – Fill Out Below ❑ No – Go to Question 10

Tell us about income for you and your husband. If you are under age 19, tell us about your parent's income (not step-parents).

Who gets it?	What is it?	How much? $_____	How often? ❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly
Who gets it?	What is it?	How much? $_____	How often? ❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly
Who gets it?	What is it?	How much? $_____	How often? ❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly
Who gets it?	What is it?	How much? $_____	How often? ❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly

10. Do you have health insurance? ❑ Yes – Fill Out Below ❑ No – Go to Question 11

Policyholder's Name _____ Coverage Start Date _____

Insurance Name and Phone Number _____

Policy Number _____ Group Number _____

What does it cover? (check all that apply) ❑ Hospital ❑ Doctor ❑ Medicine ❑ Dental ❑ Ambulance ❑ Pregnancy ❑ Family Planning

Is this policy through a job? ❑ Yes ❑ No If yes, name of employer: _____

11. Will you have the option to get insurance for your newborn? ❑ Yes ❑ No

12. Do you need Medicaid for any of the last 3 months to cover medical bills (paid or unpaid) for these months? ❑ Yes – Fill Out Below ❑ No – Go to Question 13

Which months? _____

13. **Does anyone pay for child care or care for an adult with a disability in order to work or get training?** ❑ Yes – Fill Out Below ❑ No – Go to Question 14

Name of Person Who Gets Care _____

Who pays for the care? _____

How much is paid? _____How often paid? _____

Is any help received with paying it? ❑ Yes – How much? _____❑ No

Name of Day Care or Caregiver _____

Phone Number (_____) _____

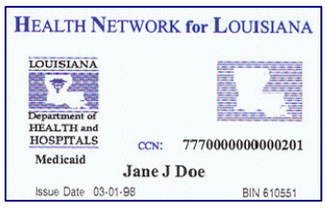
14. **Does anyone in your home pay court-ordered child support or alimony?** ❑ Yes – Fill Out Below ❑ No – Go to Question 15

Name of Person Who Pays It _____

How much is paid? _____How often paid? _____

15. **Have you ever received LaMOMS or Medicaid in Louisiana?** ❑ Yes – Answer the Question Below ❑ No – Go to Question 16

If you still have your plastic Medicaid card, you can use the same card if you qualify again. We will not send a new card unless you tell us to.

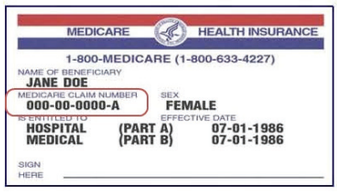


Will you need a new plastic Medicaid card? ❑ Yes ❑ No

16. **Have you ever received Supplemental Security Income (SSI)?** ❑ Yes ❑ No

17. **Do you have or have you ever received Medicare?** ❑ Yes ❑ No

The Medicare card looks like this. →



This is the end of the application. SIGN BELOW

By signing this application I am giving my permission to the State of Louisiana and its agents to make contacts to verify the information given on this application. Under penalty of perjury I certify all information I have given is true. I state that I have received and read the Rights and Responsibilities on the next page.

Sign Your Name Here:_____ **Date:** _____

Send Your Completed Application to:
LaMOMS
P.O. Box 91278
Baton Rouge, LA 70821-9278
FAX: 1-877-523-2987

YOUR RIGHTS AND RESPONSIBILITIES

Keep this page for your records.

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given at the beginning of this application form is true and correct.

REPORTING THE TRUTH: You state that the information you give on the application form is true and correct. You understand if you purposely give information that is not true OR if you purposely do not tell information that you are supposed to, you may get health benefits that you should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give about yourself will be checked. You agree to help do that and let Medicaid get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision on your eligibility for Medicaid.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: By accepting Medicaid, you understand that the Department has the right to get money received by you from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you.

REPORTING CHANGES: You agree to tell Medicaid within 10 days: 1) if you move out of state; 2) there is a change in your mailing or home address; and 3) there is any change in your health insurance and premiums.

CHILD SUPPORT ENFORCEMENT: You understand that Medicaid will send case information to Child Support Enforcement for medical support only if you ask them to.

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you may ask for a Fair Hearing if you think any decision made on your case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.

OTHER SERVICES: You understand that information about WIC, KIDMED, and other Medicaid services will be sent to you if you are eligible for Medicaid.

Documents of Proof You May Need to Send Us

If any of these things apply to you and your family, send copies of these documents. Let us know if you cannot get them. We may be able to help.

Copies of your health insurance cards (front and back).
If you are not a U.S. citizen, send a copy of your Permanent Resident Card (green card) or other form from U.S. Citizenship and Immigration Services.
If you were not born in Louisiana, send proof of U.S. Citizenship such as a birth certificate, souvenir birth certificate, U.S. Passport, or adoption papers. *If you don't have any of these things, ask us about other things you can use.*
Proof of income received by you, your husband, and if you are under age 19, your parents who live with you. Send pay stubs from last month showing gross pay (before taxes), a letter from the employer, if self-employed send copies of last year's tax return and all schedule attachments. Examples of proof for any income not received from working would be award letters, or letters from the friend or relative who is giving you or your family money.
Proof of child care payments from the day care center. Proof of payments for adult care from the caregiver.
Court order and proof of alimony or child support payments made to persons outside the home. *If it is paid through Louisiana Support Enforcement Services (SES), you **do not** have to send proof – let us know.*
If you are requesting LaMOMS/Medicaid coverage for the three months before you apply, send proof of income for those months.

IMPORTANT PHONE NUMBERS		
	PHONE NUMBER	**TTY TEXT TELEPHONE**
LaMOMS	**1-888-342-6207**	**1-800-220-5404**
EPSDT (prenatal clinics, family planning, helps with finding a Primary Care Doctor)	**1-800-359-2122**	**1-877-544-9544**
CommunityCARE (to request a change of Primary Care Doctor)	**1-800-259-4444**	**1-877-544-9544**
Physician Referral Assistance	**1-877-455-9955**	
Medicaid Services	**1-888-342-6207**	
Dental Program	**1-800-251-2229**	
Transportation (to request non-emergency transportation – call at least 48 hours in advance)	**1-800-259-1944**	
24 Hour Nurses Hotline (CommunityCARE)	**1-866-529-1681**	
Replace Medicaid Card	**1-800-834-3333**	

IMPORTANT WEB SITES	
LaMOMS – Medicaid for Pregnant Women	**www.LaMOMS.DHH.Louisiana.gov**
LaCHIP – Medicaid for Children	**www.LaCHIP.org**
Other Medicaid Programs	**www.Medicaid.DHH.Louisiana.gov**
Find a Doctor Who Accepts Medicaid	**www.La-CommunityCare.com**
KIDMED & CommunityCARE	**www.La-KidMed.com**
Apply for or Renew Medicaid	**www.Medicaid.DHH.Louisiana.gov**

KEEP THIS PAGE FOR YOUR RECORDS